Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: DALLAS COUNTY HOSPITAL P O BOX 660599 DALLAS TX 75266-0599	MFDR Tracking #: M4-10-4725-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: AMERICAN ZURICH INSURANCE COMPANY Rep Box #: 19	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "We are submitting a request for medical fee dispute based on TDI-DWC Rule 134.304. We have submitted the attached claim twice for payment. However this claim was not processed based on Medicare DRG multiplied 143%."

Principal Documentation:

1. DWC 60 package
2. Hospital Bills
3. Explanation of Benefits (EOBs)
4. Medical Records
5. Total Amount Sought $2,915.81

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "This is to advise TDI & the provider that we re submitted the bill in question to our audit company however they have advised us that this bill was processed under current IPPS values & calculations as published by CMS Medicare with the 143% Texas specific mark-up. Reimbursement is correct – no additional money allowed."

Principal Documentation:

1. Response package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
08/27/2009 through 08/29/2009	Hospital Inpatient Surgical Services	$15,324.21 (DRG 482) (IPPS) X 143% = $21,913.62 (MAR) less $18,997.81 (Total paid by respondent per Table of Disputed Services) = $2,915.81 (Due Requestor)	$2,915.81	$2,915.81
			Total Due:	$2,915.81

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 TAC §134.404, titled ***Hospital Facility Fee Guideline – Inpatient,*** effective for medical services provided in an inpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital inpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and meets the requirements for medical dispute resolution under 28 TAC §133.305 (a)(4).

1. The disputed services were denied or reduced by the insurance carrier based upon:
   Explanation of benefits dated 10/05/09 noted claim reduction code:
   - ** No denial codes or descriptions were indicted on this EOB.

   Explanation of benefits dated 01/25/10 noted claim reductions codes:
   - W1 — Workers Compensation State Fee Schedule Adjustment.
   - W1 — This line was included in the reconsideration of this previously reviewed bill.
   - BL — This bill is a reconsideration of a previously reviewed bill.

   Explanation of benefits dated 06/04/10 noted claim reductions codes:
   - W1 — Workers Compensation State Fee Schedule Adjustment.
   - W1 — This line was included in the reconsideration of this previously reviewed bill.
   - BL — This bill is a reconsideration of a previously reviewed bill.
   - BL — Additional allowance is not recommended as this claim was paid in accordance with state guidelines, usual/customary policies, or thi.
   - BL — To avoid duplicate bill denial, for all recon/adjustments/additional pymnt request, submit a copy of this EOR or clear notation that.

2. Division rule at 28 TAC §134.404(e) states, in pertinent part, that "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables."

3. Pursuant to Division rule at 28 TAC §134.404(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

4. Pursuant to Rule §134.404(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1))B) of this section, shall be reimbursed at the lesser of the manufacturers invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, which ever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: 'I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge'."

5. Upon review of the documentation submitted by the requestor and respondent, the Division finds that:
   (1) No documentation was found to support a contractual agreement between the parties to this dispute;
   (2) MAR can be established for these services; and
   (3) The submitted documentation does not support that the provider requested separate reimbursement for implantables with the billing.

6. Consequently, reimbursement will be calculated in accordance with Division rule at 28 TAC §134.404(f)(1)(A) as follows:
   The Medicare Facility Specific Reimbursement Amount including Outlier Payment Amount for DRG 482 is $15,324.21.
   $15,324.21 multiplied by 143% = $21,913.62 (MAR) less $18,997.81 previously paid by carrier = $2,915.81 due to requestor.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is $2,915.81.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031, §413.0311
28 TAC Rule §134.404, §133.305, §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provision of Texas Labor Code, §413.031, the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,915.81 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.130 due within 30 days of receipt of the Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**September 1, 2010** Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.